Acknowledgement of Interpretation of Laboratory Test Results and Receipt of Notice of Privacy Practices

Orange City Area Health System
INTEGRITY • INNOVATION • INSPIRATION

Collection:

- ☐ Draw/Kit Process ($25)
- ☐ Venipuncture ($15)

Testing:

- ☐ ABO/Rh Blood Typing ($20)
- ☐ Complete Blood Count ($15)
- ☐ Comprehensive Metabolic Panel ($25)
- ☐ CRP ($15)
- ☐ Fasting Blood Sugar ($10)
- ☐ Ferritin ($20)
- ☐ Folate ($30)
- ☐ Hemoglobin A1C ($20)
- ☐ Insulin ($30)
- ☐ Lipid Panel ($25)
- ☐ Magnesium ($10)
- ☐ Progesterone ($30)
- ☐ Prostate Specific Antigen ($30)
- ☐ Testosterone, Total ($30)
- ☐ Thyroid Stimulating Hormone ($25)
- ☐ Uric Acid ($10)
- ☐ Vitamin B12 ($30)
- ☐ Vitamin D ($45)

I hereby request the laboratory tests/screens selected above be performed for me. I understand the responsibility for initiating a follow-up examination to interpret or confirm any of the results and obtain advice and treatment is mine and not that of my physician or Orange City Area Health System. I understand that payment for testing is due prior to the testing and that Orange City Area Health System Direct Access will not submit any claims for this encounter to my insurance, Medicare, Medicaid, or any other third-party payor. I also understand results will be available in MySanford Chart but will not be reviewed by a physician unless I initiate it.

I understand the data derived from this test is not conclusive. Testing may vary depending upon age, sex, time of day sample is taken, diet, medications, and the limits of modern technology. When evaluating my health, my complete medical history must be considered – laboratory testing is only one part of the evaluation. Furthermore, laboratory tests identify certain discrete health indicators only and are in no way a substitute for a regular and thorough physical performed by my personal physician. I realize a normal result does not guarantee I do not need medical attention; likewise, an abnormal result may not necessarily be abnormal for me – my complete medical history must be considered by a physician. Also, false positive and false negative results are possible.

If I am not feeling well, I understand Orange City Area Health System recommends I see a physician immediately.

I hereby release Orange City Area Health System, its parent and affiliated companies, and their officers, directors, and employees, from any and all liability arising from or in any way connected to my failure to follow up with a physician regarding interpretation of the test results or for treatment of advice.

I hereby acknowledge I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand I should read it carefully. I am aware the Notice may change at any time. I may obtain a revised copy of the Notice by visiting https://ochealthsystem.org/privacy/.

Patient printed name:_____ DOB:_____

Patient Signature_____Date_____

✶ As the representative of the above individual, I acknowledge receipt of the Acknowledgment & Notice of his/her behalf.

✶ Signature_____Date_____

Notice of Privacy Practices: ☐ Declined Copy ☐ Received Copy
Acknowledgement of Interpretation of Laboratory Test Results and Receipt of Notice of Privacy Practices: ☐ Declined Copy ☐ Received Copy

Staff Signature_____Date_____

Total Amount Paid $_____

Lab 1126